

FILED NOV 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41307
STATE FILE NUMBER

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 86

300
-57

1. PLACE OF DEATH a. COUNTY Osage		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Osage	
b. CITY (If outside corporate limits, give TOWNSHIP only) Crawford Township		c. CITY OR TOWN Linn	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) RFD	
3. NAME OF DECEASED (Type or print) First OREN Middle BERNICE Last POTTS		4. DATE OF DEATH Month Nov. Day 14 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Sept 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Television Service Sep. Empl.		11. BIRTHPLACE (City and state or country) Linn, Mo.	
13a. FATHER'S NAME Leonard Potts		14. NAME OF HUSBAND OR WIFE Louisa Minerva Potts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 492 09 3863	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery thrombosis		INTERVAL BETWEEN ONSET AND DEATH Four days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 4201			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Linn		COUNTY Osage STATE Mo.	
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at 9:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. L. J. Swell		22b. ADDRESS Box 338 Linn, Mo.	
22c. DATE SIGNED 11/15/57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 17 Nov 1957	
23c. NAME OF CEMETERY OR CREMATORY High Gate		23d. LOCATION (City, town, or county) (State) High Gate, Mo.	
24. FUNERAL DIRECTOR Clyde Morton		25. DATE RECD. BY LOCAL REG. Nov. 16-1957	
ADDRESS Linn, Mo..		26. REGISTRAR'S SIGNATURE T. A. Subonille	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NOV 21 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.